PRINTED: 05/23/2012 Division of Health Care Facilities FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING TN9301 05/22/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LIFE CARE CENTER OF SPARTA **508 MOSE DRIVE** SPARTA, TN 38583 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) **PREFIX** TAG TAG **DEFICIENCY**) N 000 Initial Comments N 000 During a complaint investigation at Life Care Center of Sparta on May 22, 2012, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes. C/O: #29811, #29590

Division of Health Care Facilities

TITLE

(X6) DATE

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TATE FORM

DPLW11

If continuation sheet 1 of 1